Fort Leavenworth

Family Life Chaplain
Intake Form

Soldier Resiliency Center
600 Thomas Avenue
W. 913-684-8995
Fax: 913-684-8994

Please write legibly

Patient Information		
Patient Full Name:		Date of Birth:
Gender: ☐ Male ☐ Female	Marital Status: Years? _____ ☐ Single ☐ Married ☐ Other (see below)	Unit:
Address:	City/State/Zip:	
Home Phone: Leave MSG? ☐ Yes ☐ No	Work Phone: Leave MSG? ☐ Yes ☐ No	Cell Phone: Leave MSG? ☐ Yes ☐ No
Emergency Contact Name:	Emergency Contact Phone:	

Personal History

If you need more space for any of these questions please use the back of the sheet

Primary reasons for seeking services (check all that apply):

☐ Anger Management ☐ Anxiety ☐ Depression ☐ Trauma ☐ Financial Issues
☐ Eating Problems ☐ Fear ☐ Sexual concerns ☐ Divorce/Separation ☐ Fighting in home
☐ Sleeping Problems ☐ Affair ☐ Drug/Alcohol ☐ Religious Concerns ☐ Suicide/Homicide

☐ Other Concerns: _____

Family Information

Relationship	*Name*	*Age*	*Living*	*Living with you*
Father			☐ Yes ☐ No	☐ Yes ☐ No
Mother			☐ Yes ☐ No	☐ Yes ☐ No
Spouse			☐ Yes ☐ No	☐ Yes ☐ No
Children			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

Significant Others

(e.g. brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship).

Relationship	*Name*	*Age*	*Living*	*Living with you*
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

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Marital Status *If you answered "other" above please clarify*				
Widowed How long:_____ How many times:__	Divorce in process How long:_____ How many times:_	Separated How long:_____ How many times:_	Annulment How long:_____ How many times:	Living together How long:_____ How many times:
Assessment of current relationship: ☐ Good ☐ Fair ☐ Poor				
Parental Information				
Legally Married How many times:__	Ever Separated How many times:_	Ever Divorced How many times:_	Father Remarried How many times:	Mother Remarried How many times:
Special Circumstances (e.g. raised by someone other than parents, etc.):				

Deployment History		
Deployed to:	How long: _____months	Dates: From_____ To_____
Deployed to:	How long: _____months	Dates: From_____ To_____
Deployed to:	How long: _____months	Dates: From_____ To_____
Deployed to:	How long: _____months	Dates: From_____ To_____
Deployed to:	How long: _____months	Dates: From_____ To_____

Development

Has there been a history of child abuse? ☐ Yes ☐ No
If yes which types: ☐ Physical ☐ Verbal ☐ Emotional ☐ Sexual ☐ Neglect
If yes, the abuse was as a ☐ Victim ☐ Perpetrator
Comments:

Spiritual/Religious

How important to you are spiritual matters? ☐ Not ☐ A little ☐ Moderate ☐ Much
Are you affiliated with a spiritual/religious group? ☐ Yes ☐ No

If yes, which one? _____
Were you raised in a spiritual/religious home? ☐ Yes ☐ No

If yes, describe: _____
Comments:

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Education *(fill in all that apply)*			
Years of education:		Currently enrolled: ☐ Yes ☐ No	
School	*Number of years*	*Graduated*	*Major*
High School/GED		☐ Yes ☐ No	
Vocational		☐ Yes ☐ No	
College		☐ Yes ☐ No	
Graduate		☐ Yes ☐ No	
Post-Graduate		☐ Yes ☐ No	
Other		☐ Yes ☐ No	

Chemical Use History
(Please include all prescription drugs)

Drug	*Method*	*Amount*	*Frequency*	*Age of first use*	*Age of last use*

Reasons for use:
☐ Addicted ☐ Socialization ☐ Build Confidence ☐ Taste ☐ Escape ☐ Help Sleep ☐ Other

How do you believe your substance use affects your life? _____
Who or what has helped you in stopping/limiting your use? _____
Is there a family history of drug/alcohol use in your family? _____
Have drugs or alcohol created a problem for you? _____

Counseling/Treatment History

Are you currently seeing another counselor/psychologist/psychiatrist for any reason? ☐ Yes ☐ No
If yes, are you willing to allow collaboration between us to better help you? ☐ Yes ☐ No
What did you like about prior counseling received?

What did you not like about prior counseling received?

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Any additional information that would assist us in understanding your concerns:
What are you goals for therapy?
Do you feel suicidal at this time? ☐ Yes ☐ No If yes, explain:

Your Rights

Therapy is the process of solving emotional problems by talking with a person professionally trained to help people achieve a more fulfilling individual life, marital/couple relationship, or family relationships.

The process of change will, in many ways, be unique to your particular situation. Who you are as a person will help to determine the ways in which you go about changing your life.

As the client, you have the right to ask your therapist questions about his or her qualifications, background, and therapeutic orientation. The most important factor in the success of therapy is good communication between therapist and client.

If you are a minor, you have a limited right to privacy in that your parents may have access to your records. However, if the therapist believes that sharing this information will be harmful to you, confidentiality will be maintained to the limits of the law.

You have the freedom to place grievances and recommend changes in policies and services to CFLC staff free from restraint, interference, coercion, discrimination, or reprisal.

In some instances, talking about your difficulties may exacerbate your symptoms, however over time you should see an improvement. In addition, not all individuals benefit from therapy or working with a particular therapist.

If at any time during the therapy you have questions about whether or not the treatment is effective, feelings about something your therapist has said or suggested or need clarification of our goals, do not hesitate to bring this up in your session or call the chaplain's clinical supervisor at (913) 684-6771. You may also contact the Kansas State Behavioral Sciences Regulatory Board regarding license # LMFT 2441 at (785) 296-3240.

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Informed Consent:	
Privacy Act Statement The authority for soliciting this information comes from 10 USC 3012. The purpose for soliciting this information is to provide the family life chaplain personal information to assist in the pastoral counseling you are seeking. The information you provide will be maintained under strict professional guidelines at the Chaplain Family Life Center until termination of services and the case file is shredded. Providing the information is voluntary. There will be no adverse effect on you for not furnishing the information. However, failure to provide certain information will hinder the family life chaplain in providing you the most effective pastoral care. Initials _____, _____ I give my permission for the family life chaplain to make video recordings of our sessions to use for professional review, and to share these recordings with his supervisor for the purpose of promoting the highest quality of counseling services to clients. All video records and written materials will be treated with strict confidentiality in compliance with the Chief of Chaplain's policy on chaplain confidentiality below. All video records will be destroyed after no more than 10 days following termination of the counseling relationship. Initials _____, _____ This center complies with the **Chief of Chaplains Policy for Confidential and Privileged Communications as stated in paragraph 16-2 of AR 165-1**. All information you disclose to the Family Life Chaplain is considered to be a religious act and therefore confidential. All information is considered privileged communication for legal purposes. Privileged or Confidential communication will only be released to third parties with your voluntary decision to do so, and will not be released without consent from you. Initials _____, _____ *My signature below indicates that I am consenting to counseling at the Chaplain Family Life Counseling Center and have received and understand the contents of the Pastoral Counseling Services including the notice of confidentiality and use of video recordings for use in clinical supervision. If I have questions, the information has been explained and/or summarized for me.*	
Signature(s) – Required for services	Date:
Therapist's Signature/Credentials:	Date:
Supervisor's Comments: Signature/Credentials (if comments are given):	Date:

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